North Carolina Department of Health and Human Services – Division of Medical Assistance

CONFIDENTIAL **CAP-C CRITICAL INCIDENT REPORT** *CONFIDENTIAL*

Provider Agency Name

Recipient's Name and MID number

Instructions: Complete and submit this form to the Division of Medical Assistance, Home Care Initiatives Unit (fax (919) 715-9025) within 72 hours of learning of the incident. If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible**. The staff person who is most knowledgeable about the incident should complete pages 1-2 of this form as soon as possible after learning of the incident and submit it to DMA**.

Date of Incident (if known) and/ or date you became aware of incident: _____
Time of Incident (if known) and/or time you became aware of incident _____ □ a.m. □ p.m. □ unknown

Recipient Information

Recipient's Date of Birth _____ Recipient's county _____ Recipient's Gender □ male □ female
Recipient's Ethnicity
□ White/Anglo □ Black/African American □ Hispanic/Latino
□ Native American □ Asian/Pacific Islander □ other (*specify*) _____

Incident Information

Location of Incident
□ recipient's legal residence
□ community
□ other (*specify*)
□ unknown

Other People Involved *(Provide the name(s) of the person and his/her relationship to the recipient that is the subject of the report.)*	provider	family	other
1._____	□	□	□
2. _____	□	□	□
3. _____	□	□	□
4. _____	□	□	□
5. _____	□	□	□

Was the recipient under the care of the reporting provider at the time of the incident? □ Yes □ No
Was the recipient treated by a licensed health care professional for the incident? □ Yes □ No Date: _____
Was the recipient seen by the family physician? □ Yes □ No Date: _____
Was the recipient seen in the ER? □ Yes □ No Date: _____
Was the recipient hospitalized for the incident? □ Yes □ No Date: _____

TYPE OF INCIDENT

RECIPIENT DEATH

Death due to: □ Terminal illness/ natural cause □ suicide □ motor vehicle accident □homicide/violence □ injury □ unknown cause □ n/a

INJURY

Report injuries requiring treatment by a licensed health professional or change in plan of care
(Check only one)

Injury due to:
□ decubitus
□ equipment malfunction/ non-maintenance
□ aggressive behavior
□ exaggerated reaction or adverse sexual behaviors
□ assault, rape
□ physical abuse of recipient
□ self-injury/mutilation
□ trip or fall
□ impaired mobility/balance
□ auto accident
□ delay in treatment
□ ineffective communication
□ denial of care
□ refusal of care
□ wandering
□ suicide attempt
□ other *(specify)* _____
□ n/a

ABUSE ALLEGATION

(check all that apply)
□ alleged abuse of a recipient
□ alleged neglect of a recipient
□ alleged exploitation of a recipient

Was a report filed with CPS?

□ Yes □ No Date: _____

Report any alleged or suspected case of abuse, neglect or exploitation of a recipient (physical, sexual, psychological abuse or financial mistreatment) as required by law, to the county Dept. of Social Services, to the DFS Healthcare Personnel Registry (if appropriate) and to DMA.

□ n/a

MEDICATION ERROR

Report errors that threaten health or safety or cause adverse reactions
(Check only one)
□ wrong dosage administered
□ wrong medication administered
□ wrong route for medication administered
□ wrong time (administered more than one hour from prescribed time)
□ missed dosage (including refusals)
□ n/a

HOSPITALIZATION/ ED VISITS

□ planned?
□ unplanned?

Name of Hospital _____
Length of stay _____
Reason: _____

Outcome: _____

□ n/a

OTHER INCIDENT

□ **involuntary** suspension of a recipient from services [enter number of days _____]
□ OTHER _____
□ significant under- or over- utilization of services or misuse of services
□ Theft _____
□ n/a

Note: Incident reports are confidential quality assurance documents, protected by GS 122 C-30, 122 C-191, and 122 C-192. Do not file incident reports in the recipient's service record. Confidentiality of recipient information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR, parts 160 and 164

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Incident Description

Describe the incident, including Who, What, When, Where and How. *(Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Attach additional pages if needed. Do not provide another recipient's name or identifying information here.)*

PROVIDER RESPONSE

Describe the cause of the incident (attach additional pages if needed):

Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of the incident (attach additional pages if needed):

PORTING INFORMATION

Indicate authorities or persons notified of the incident (as applicable):

Agency/Person	**Contact name**	**Phone**	**Notification Date**	**initials**
☐ CAP-C CM Agency				
☐ CAP-C HH Agency				
☐ CAP-C HC Agency				
☐ Physician				
☐ Law enforcement				
☐ County DSS				
☐ Health Care Personnel Registry				
☐ Parent/Guardian				
☐ NC DFS Complaint Unit				
☐ Board of Nursing				
☐ Other				

Name/title of **staff person** documenting incident (please print)

_____ phone: ( ) _____

Signature _____ Date _____ time _____ ☐ a.m. ☐ p.m.

Name/title of **supervisor notified of report** (please print)

_____ phone: ( ) _____

Date _____ time _____ ☐ a.m. ☐ p.m.

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